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How African American Adolescents Manage Depression: Being With Others

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Abstract

BACKGROUND: African American (AA) adolescents with depression face serious negative outcomes. Despite racial/ ethnic disparities in treatment utilization, few studies have explored how AA adolescents manage their depression.

OBJECTIVE: To describe common ways AA adolescents manage depressive symptoms through relationships with people in their lives.

DESIGN: Qualitative descriptive methods were used to analyze the narratives of 22 AA young adults who had been depressed as adolescents and 5 AA adolescents in treatment for depression.

RESULTS: A typology describing the varied ways AA adolescents manage their depressive symptoms through interactions with other people was constructed and labeled Being With Others. The five categories in the typology are *keeping others at bay*, *striking out at others*, *seeking help from others*, *joining in with others*, and *having others reach out*.

CONCLUSIONS: Clinicians might use the Being With Others typology to guide discussions related to detecting, assessing, and treating AA adolescents with depression.

Keywords

African American; adolescents; depression; social support; coping

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Authors' Note

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Author Roles

Dr. Al-Khattab conducted the study and prepared, wrote, and edited the article. Dr. Draucker assisted with study design, data analysis, and preparing the article. Drs. Oruche and Perkins assisted with data analysis and writing and editing the final version of the article.

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Depression in African American (AA) adolescents is a serious mental health problem in which feelings of sadness, loss, anger, or frustration interfere with everyday life (American Psychiatric Association, 2000; U.S. National Library of Medicine, 2011). According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*®), a major depressive episode occurs when individuals experience a depressed mood or a marked loss of interest or pleasure in daily activities for a period of at least 2 weeks. These changes are accompanied by a variety of the following symptoms: a significant change in weight, appetite, or sleep habits; restlessness; fatigue; feelings of worthlessness or guilt; indecisiveness; and suicidal ideation (American Psychiatric Association, 2013). There are three types of depressive disorders. Major depressive disorder is characterized by one or more major depressive episodes. Dysthymic disorder is characterized by the presence of a depressed mood for a minimum of 2 years, accompanied by additional depressive symptoms that do not meet diagnostic criteria for major depressive disorder. Depressive disorder not other-wise specified is characterized by depressive features that do not meet criteria for major depressive disorder, dysthymic disorder, or other disorders with depressive features (American Psychiatric Association, 2013).

The Substance Abuse and Mental Health Administration (2014) reported that depression is experienced by an estimated 8.6% of 12-to 17-year-old AA adolescents, with more than 70% suffering from severe impairment. In the 2013 Youth Risk Behavior Surveillance Survey, more than one in four (27.5%) AA high school students surveyed reported having had their usual activities impaired by prolonged feelings of sadness or hopelessness during the previous 12 months (Centers for Disease Control and Prevention, 2013).

Depression in adolescents is associated with a number of other health concerns, including high-risk sexual behavior, early pregnancy, substance abuse, poor academic performance, psychosocial functioning impairment, and increased risk for suicide (Chandra et al., 2009; Rao & Chen, 2009). Suicide is the third most common cause of death in the United States among adolescents. Of adolescents who commit suicide, 90% are experiencing a psychological disorder, most commonly depression, at the time they end their lives (Colucci & Martin, 2007; Goldstein, 2008). Depression in adolescence is also associated with recurrent depression in adulthood. Approximately half of adolescents who experience depression will also experience depression as young adults (Alexandre, Dowling, Stephens, Laris, & Rely, 2008; Curry et al., 2011).

Although rates of depressive disorders in AA adolescents and their European American (EA) peers are similar (8.6% and 10.9%, respectively; Substance Abuse and Mental Health Services Administration, 2014), startling disparities exist in mental health treatment utilization (Brawner & Waite, 2009). One survey of a nationally representative sample of 13-to 17-year-old adolescents indicated that only 39% of respondents with depressive disorders had ever received mental health treatment. Moreover, AA adolescents with depressive disorders were 87% less likely than their EA counterparts to have ever received mental health treatment (Merikangas et al., 2010).

The underutilization of mental health services has serious consequences for AA adolescents. AA adolescents with social and emotional disorders are more likely than EA adolescents

with similar problems to enter the juvenile justice system (Olfson, Gameroff, Marcus, & Waslick, 2003; Substance Abuse and Mental Health Services Administration, 2011). High rates of substance abuse, academic failure, and high arrest and incarceration rates are problems disproportionately experienced by urban AA adolescents (Olfson et al., 2003; Substance Abuse and Mental Health Services Administration, 2011), and some experts suggest that unrecognized and untreated mental illness may underlie these problems (Hicks, 2011). Additionally, while overall rates of suicide attempts among adolescents have decreased recently, rates among AA adolescents, a group that has historically had a lower rate than other ethnicities, have increased (Centers for Disease Control and Prevention, 2013).

Despite a low rate of treatment utilization for AA adolescents, few studies have explored how they manage their depression in the absence of formal treatment. Depressed AA adolescents who do not receive adequate mental health services are faced with managing their symptoms either alone or with informal supports (Draucker, 2005; Lindsey et al., 2006). Some research suggests that they use religion and spirituality and rely on religious leaders, family, and friends to help them cope with their distress (Breland-Noble, Burriss, & Poole, 2010; Lindsey et al., 2006; Matthews, Corrigan, Smith, & Aranda, 2006).

Social support has been identified as a protective factor for adolescent psychological well-being in a variety of stressful life events (Cheng et al., 2014) and specifically for adolescents who are depressed and suicidal (Merchant, Kramer, Joe, Venkataraman, & King, 2009). Social support has been broadly defined as those perceived or actual interpersonal social resources that facilitate coping with life stressors (Lin, Dean, & Ensel, 2013). Family support has been shown to promote healthy psychological adjustment (Kuhn & Laird, 2014) and to protect against suicidality (Kleiman & Liu, 2013) and depressive symptoms (Natsuaki et al., 2007) in AA adolescents. Peer support has also been shown to influence mental health outcomes; poor-quality interactions are associated with depressive symptoms, and high-quality peer interactions can protect against suicidality in depressed adolescents (Matlin, Molock, & Tebes, 2011). A recent study that examined the impact of family and peer support on depression and suicidality in a community-based sample of AA adolescents showed that family support protects AA adolescents from depressive symptoms, and at lower levels of depression, peer support has protective effects as well (Matlin et al., 2011).

Although research has shown that family and peer support can influence how AA adolescents experience depression, especially in light of low treatment utilization, few in-depth descriptions of how depressed AA adolescents interact with important others are available. Such information can provide the basis for a better understanding of how AA adolescents manage their depression. This understanding may provide a foundation to develop strategies to explore with AA adolescents how their relationships influence how they manage their depression and to support significant others who wish to help depressed AA adolescents. The purpose of this study was to describe common ways in which AA adolescents manage depressive symptoms through their relationships with other people in their lives.

Method

The data used for this report are drawn from an ongoing larger study in which grounded theory methods (Charmaz, 2006) are being used to develop a theoretical framework that describes how AA adolescents understand their depression and its effects, manage their symptoms, and, in some cases, seek and use mental health services over the course of their adolescent years. The larger study, called the African American Adolescent Depression Study, will be first discussed because it provided the data for the findings reported here. Institutional review board approval was obtained from the first author's university for the larger study. All the procedures used in the study reported here, including the data analysis, fell within the scope of the institutional review board approval for the larger study.

The African American Adolescent Depression Study

Sample.—Two participant populations of AAs were recruited to gather descriptions of a broad range of depressive experiences and treatment pathways. Young adults ages 18 to 21 years who reported that they had experienced depression during adolescence (ages 13–17) were recruited to participate in a retrospective interview. Community-based young adults were recruited to reflect back on their teen years for several reasons. First, they were able to provide information about their experiences with depression throughout adolescence and as they transitioned into young adulthood. Second, because research has shown that the majority of depressed adolescents hide their depression from their parents, young adults could provide data on living through depression without the requirement of parental consent. Finally, recruiting community-based young adults yielded participants who had not necessarily received treatment for their depression and who could thus provide data on managing depression without the benefit of mental health services. In addition, adolescents ages 13 to 17 years receiving treatment for depression were recruited to participate in an interview about their current experiences. These adolescents were able to provide contemporaneous information about their experiences of depression, had a formal diagnosis of depression, and experienced symptoms that were severe enough to warrant mental health care. Depression is a sensitive topic, and participants may have been reluctant to discuss particularly painful experiences. Experts suggest that enhanced rapport and disclosure can be established and cultivated if the interviewer is of the same race/ethnicity as the participant (Krysan & Couper, 2003). Both the participants and interviewer in this study were AA, possibly limiting response bias (Alderfer & Tucker, 1996).

Young adults.—Twenty-two AA young adults ages 18 to 21 years who had experienced depressive symptoms during adolescence (ages 13–17) were recruited by community-based sampling using public announcements and community networking. Recruitment was conducted within five postal areas in the Indianapolis metropolitan community, including three neighborhoods that were pre-dominantly AA and two neighborhoods that were racially mixed yet with a substantial AA population. The primary investigator canvassed the five communities to assess locations frequented by young adults where recruitment flyers could be distributed, identify publicly accessible yet private locations that could be used as interview sites, and speak with community leaders about the study and enlist their support.

The investigator distributed recruitment flyers in each community announcing the study on depression in AA adolescents. The flyers included a description of depressive symptoms taken from the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; *DSM-IV-TR*®; American Psychiatric Association, 2000) criteria but written in lay language. The flyers invited young adults ages 18 to 21 years who had experienced depression between ages 13 and 17 to contact the investigator. Flyers were placed in a variety of locations, including restaurants, gyms, postsecondary schools, public libraries, grocery stores, and malls. The flyers indicated that interviews could be conducted in local community settings and that participants would receive a $35 gift card reimbursement for their time and travel after the interview was completed.

The investigator screened potential participants over the phone for the following inclusion criteria: (a) self-identify as being AA; (b) aged 18 to 21; (c) speak, read, and write the English language; and (d) report having experienced depressive symptoms during adolescence or having been diagnosed with depression by a health professional. After receiving verbal consent, the investigator used an adapted screening protocol (Draucker, Martsolf, & Poole, 2009) to screen for the following exclusion criteria: (a) experiencing acute distress or a recent life crisis; (b) recent hospitalization for mental health concerns; (c) current suicidal ideation; and (d) current homicidal ideation. No individuals who were screened were excluded from the study.

Adolescents.—After obtaining approval from a large publicly funded medical center in Indianapolis, the investigator recruited five 13-to 17-year-old AA participants from an adolescent primary care clinic. Inclusion and exclusion criteria were identical to criteria for the young adults with the following exceptions: (a) participants were between 13 and 17 years of age and (b) currently receiving treatment for depression from a health professional. Clinic staff were provided information about the study and identified potentially eligible participants using clinical records. With approval from the primary care provider, the investigator approached eligible participants about the study.

Data Collection

Young Adults.—The investigator scheduled interviews in the participants' communities in a location that offered privacy for the interview (e.g., library meeting rooms, conference rooms in community centers) at a time that was convenient for the participant. The participants signed informed consent forms and completed a demo-graphic data sheet. The investigator screened participants for distress prior to, during, and after the interviews. The interviews were semistructured and began with the following question: "You indicated that you experienced depression as a teenager. Would you tell me about that experience?" Other questions were aimed at how the participants had managed their symptoms and how they had used mental health services. The interviews were digitally recorded and professionally transcribed.

Adolescents.—Data collection procedures for the adolescent participants were identical to the procedures for the young adults with the following exceptions: (a) written consent was obtained from the adolescents' parent/guardian, and written assent was obtained from the

adolescents; (b) questions were about the participants' current experiences with depression rather than their retrospective experiences; and (c) participants were asked about their experiences leading up to receiving mental health treatment as well as with the treatment itself. All interviews were conducted in an available patient exam room at the clinic. After informed consent and assent were obtained, the interview was conducted without the parent or guardian in the room. Adolescents were screened for acute distress before, during, and after the interview, and no individuals who were screened were excluded from the study.

Data Analysis

The research team members read the 27 transcribed interviews in their entirety to get an overall understanding of the salient issues discussed by the participants. This initial review revealed that participants' interactions with others were clearly a major focus of the narratives. The team therefore decided to explore this phenomenon in greater depth. The team sought to develop a typology since it was evident that there were several different ways in which the participants interacted with others, and the interactions seemed to reflect attempts to manage depression.

To develop this typology, content analytic procedures according to Krippendorff (2012) were used. Each transcript was reread, and any text unit (e.g., phrase, sentence, complete story) about interacting with others was highlighted, extracted, and coded. The codes were labels that captured the essence of each text unit as it related to the research aim. The first author created coding tables and grouped similar codes together to facilitate comparison of text units. The categorization of codes was tracked using the qualitative data analysis software program NVivo. The first and last authors compared and contrasted the coded text units (n = 302) and through dialogue and consensus used an iterative process to group codes that shared similarities. They determined that all of the text units could be classified into one of five categories. The first and last authors reexamined the codes, named the categories, and constructed a definition for each. The first author created a series of data matrices to display the codes and categories and to further divide the codes in each category according to participant gender and specific features of the interactions captured by the codes, including people involved with the interactions, places where the interactions took place, types of interactions, and outcomes of the interactions. The data displays were presented to the second and third authors, and the category names and definitions were discussed by the entire team and refined. All authors then independently verified that each text unit was appropriately categorized. A narrative summary of the features of each category was written by the first author and reviewed by the other authors.

Results

Sample

All 27 participants from the parent study described ways in which they had managed their depressive symptoms through their relationships with other people in their lives. The entire study sample is therefore described below. In addition, demographic data for the sample can be found in Table 1.

Young Adults.—The young adult sample included 22 young adults ages 18 to 21, with a mean age of 20.1. Twelve were females, and 10 were males. All identified as AA, although four also identified as more than one race. Eleven were employed, 11 were unemployed, and of the 22, 7 were students. Twelve of the young adults had no children, seven had one child, one had two children, and two did not provide information about children. Nine were Christian, two were Muslim, two reported having no religious affiliation, and 11 did not report religious affiliation. Six participants reported their annual house-hold income as less than $19,999, two as $20,000 to $39,999, three as $40,000 to $99,999, four were unsure, and seven did not report an annual household income.

Adolescents.—The adolescent sample included five individuals ages 13 to 17, with a mean age of 14.4. Three were female, and two were male. All identified as AA; however, two also identified as more than one race. All five were students, and one was employed. Three were Christian, and two did not report a religious affiliation.

The Being With Others Typology

We labeled the typology as “Being With Others” to reflect that the participants’ interactions with others were best understood as relationship patterns that were embedded in their day-to-day lives rather than as discrete interactions that the participants viewed as ways of coping. The participants’ ways of interacting ranged from withdrawing from all others to avoid rejection or judgment to being fully engaged with others as a way of getting help with depression. The five categories of Being With Others included *keeping others at bay, striking out at others, seeking help from others, joining in with others*, and *having others reach out*. Participants often used more than one way of Being With Others to manage their depressive symptoms.

Table 2 displays the five categories, the definition for each category, the number of participants who contributed to each category, and the number of text units that contributed to each category. The categories within the Being With Others typology are described and discussed below. Participants are referred to only by their gender and their age at the time of the interview to protect their identities. Although some participants were between 18 and 21 years of age at the time of the interview, all examples refer to events that occurred while participants were between the ages of 13 and 17.

Keeping Others at Bay.—One way that the participants experienced Being With Others was by keeping them at bay. By keeping others at bay we mean instances in which the participants had prevented people from knowing about, acknowledging, or trying to help with the participants’ depression. The ways participants kept others at bay, the people they kept at bay, and the reasons they kept others at bay are described below.

Many participants kept others at bay by hiding feelings of depression. One 19-year-old female participant felt she could not talk to her family about being depressed and thus “kept it all bottled up.” When the participants had been asked how they “were doing,” they often denied they were distressed and instead replied everything was “fine” or “okay.” Participants also hid their feelings of sadness by pretending to be happy. A 21-year-old female participant stated,

> I would put on a smile for my parents and my siblings. Whenever somebody would leave and I knew I was going to be alone, they would ask me, “Are you going to be alright?” And I would say “Yes, of course,” because I didn’t want them to know what I was dealing with. But, it was a living hell. I put up a really good façade for them, like all cheery and happy, nothing’s wrong. They didn’t suspect anything.

Similarly, during therapy or counselling sessions, participants had often chosen to tell their counselors “what they wanted to hear” instead of disclosing their true feelings.

Many participants had kept others at bay by avoiding them. Female participants were particularly likely to stop spending time with their friends. One 21-year-old female participant said, “I had a best friend at the time, I wasn’t hanging out with her as much.” Participants also often stopped participating in activities they had previously enjoyed or failed to fully engage in the activities. A 19-year-old female participant who had been a performer since the age of two revealed, “I was in show choir and throughout that year I just didn’t really enjoy it. I was fine with standing in the back, which really wasn’t like me. My wanting to be in the back just wasn’t normal.” Some participants avoided others by spending time in their rooms or going for walks alone. One 19-year-old female participant said, “I just kind of wanted to be by myself.”

Participants kept a variety of people at bay. Participants were most likely to keep their family members at bay for fear these persons would try to intervene with their depression. One 19-year-old female participant explained, “I would come home from school and just sleep and then I would eat dinner and go back to sleep.” Participants also kept friends and romantic partners at bay so peers would not view them as depressed and therefore different. As mentioned above, many participants had kept therapists or counselors at bay especially if the participants had not chosen to be in therapy. Other participants did not have one particular group of people they kept at bay but rather isolated themselves “from everyone.”

Participants kept others at bay for a number of reasons. Most participants were ashamed that they were depressed and afraid of what others might think. A 20-year-old female participant said, “I didn’t want people to talk about me. I didn’t want them to say I was weak.” Some participants believed they should deal with their problems alone. An 18-year-old male participant shared, “I don’t like talking about how I feel with people I’m close to because it affects them. It’s better to keep things to myself. I feel like, when you have a problem internally, you deal with it your-self.” Participants had kept others at bay fearing that if they “opened up” they would be ridiculed or shunned. A few participants feared being removed from their parents’ custody if they “said too much” to an untrustworthy counselor or teacher.

Striking Out at Others.—Participants also experienced Being With Others was by striking out at them. By striking out at others we mean instances in which the participants had lashed out verbally or physically. The types of behaviors they exhibited, the people they struck out against, and the events that surrounded their striking out are described below.

Several participants indicated that they experienced their depression as anger rather than sadness, and because they “bottled up” their feelings, their anger was easily triggered by others. Nearly all of the participants at some point struck out at others to express or release

their feelings of anger. Several had confrontations with others that included angry outbursts of yelling or cursing. Female participants in particular often used insulting, rude, or intentionally hurtful language when feeling angry. One 16-year-old participant described how she had verbally attacked a classmate: “I actually used lyrics of a song that I knew very well to verbally abuse her.” Both male and female participants released built-up anger by throwing objects like cell phones or chairs or by engaging in physical altercations.

The participants struck out at a variety of people. Some participants exhibited a rude or hostile attitude to almost everyone with whom they interacted. A 16-year-old female, for example, “took out” her feelings on “any and every-one.” Some participants who felt picked on by others at school had retaliated with verbal outbursts and physical attacks on their classmates. One 21-year-old female talked about her response to being teased at school: “I would just go around the classroom, or in the hallway, be mean to them. They talked about me being pregnant, I’d be ready to fight.” Other participants were aggressive toward siblings or other family members, and several had “flipped out” against those close to them. A few participants hit or kicked random strangers. One 21-year-old male described an assortment of people his anger had been directed toward: “I might be arguing with my brother, or I might get into it with somebody at the gas station, or I might be driving and somebody might cut me off and I’m heated.”

Striking out at others transpired in a number of ways. Some participants intentionally provoked confrontations at school or home in response to a perceived slight from peers or family members. When describing how altercations with classmates who “brushed her a certain way” typically occurred, one 13-year-old female participant stated, “Usually they make me angry, I cuss them out or I try to fight them.” Other participants had unexpected out-bursts during interactions that they realized did not warrant such an intense angry response. One 21-year-old male found himself “blowing up and not knowing why” despite not wanting to argue with others. He was confused by his own behavior and stated, “Why is it even making me upset, this upset?” Several participants were unaware that their behavior had been perceived as hostile and were surprised to learn they had offended others and were seen as rude and mean. One 21-year-old female said, “I didn’t even know when I was being mean.” A few participants hit, kicked, or verbally attacked others with no provocation. A 20-year-old female who had been depressed after the death of her father talked about how she dealt with her emotional pain while at school:

> If someone walked up to me, I would kick them or punch them, and it made me feel better. I’d say something to them to the point where we’re about to fight, and it would be like a relief. It sounds weird, but I noticed when I act out, I feel better.

Seeking Help From Others.—Another way that the participants experienced Being With Others was by seeking help from them. By seeking help from others we mean instances in which participants had sought help from someone in response to their feelings of depression. The ways participants sought help, the people they sought help from, and the outcomes of seeking help are described below.

Participants had sought help from others in a number of ways. Most participants who sought help did so by revealing their feelings to or discussing their problems with others. Some participants "let it out" by venting their frustrations to others, and other participants talked out their problems with others to get help in finding a solution to them. A 20-year-old female participant sought help from her godmother so they could figure out together how to "deal with" the participant's problems.

Some participants asked others to do activities with them as a distraction from their negative feelings. One 21-year-old female participant asked her mother to go to the mall even if they did not have money to purchase any-thing. She told her mother, "We'll just go window shopping, it doesn't matter, let's just get out and do something." Other participants engaged others with "cries for help." A 21-year-old female participant described how she had called her best friend to say goodbye moments before attempting suicide: "I was crying while I was talking to her. I could barely get the words out of my mouth, but I said '[Friend] I'm calling you to say goodbye.' And I hung up."

Participants were likely to seek help from people they knew well, especially family members. They sought help from parents, siblings, aunts, grandmothers, and foster parents or godparents. Participants most commonly sought help with their feelings of depression from their mothers. One 22-year-old male participant talked to his mother when he was upset because she would help him to "calm down." Participants also had sought help from professionals such as counselors, teachers, and clergy. One 21-year-old female said, "I talked to a lot of my high school teachers. I would talk to them whenever I was feeling down or something was wrong." Several participants had sought help from people they identified as mentors. One 19-year-old male participant described why he felt comfortable seeking help from his mentor: "She watched me grow up since I was young, up until I was in the ninth grade. She had been there and she used to mentor my sister, so I felt I could talk to her."

Seeking help from others commonly resulted in positive outcomes for the participants. Most participants experienced a decrease in feelings of sadness, anger, and loneliness after seeking help from others. One 21-year-old female participant felt that simply talking to her grandmother helped "heal a lot." Participants typically felt understood, loved, or supported after talking about their feelings or problems and felt particularly connected to their confidants. One 21-year-old female participant who talked about her feelings with a close friend felt the friend "was really listening." One 19-year-old male participant found talking to peers in group counseling sessions to be helpful because he felt he was "not the only one out there" dealing with depression. Seeking help also enabled participants to receive advice or help in solving their problems. A few participants had been connected to formal mental health services as a result of seeking help from others. One 21-year-old female participant said, "I told my friend about everything that was going on. She was concerned and suggested that I talk to one of the counselors at the school."

Seeking help from others, however, did not always result in positive outcomes. A few participants were rejected by those from whom they sought help. One 21-year-old female participant who had tried seeking help from her twin sister said,

> It would basically go in one ear and out the other. [My sister] would be like, “Oh girl, just shut up. Everything is going to be alright.” And then she’d go on her merry little way. Like she [wouldn’t] take me seriously. I’d be like, “I’m dead serious.” I’d be sitting there bawling in front of her face and she’d be like “Oh, okay, you’re alright.” Like it was a little game. It was not a game.

Some participants grew discouraged when they had attempted to contact others when feeling down but could not “reach” them. A few participants were devastated when their pleas for help were ignored.

Joining In With Others.—Participants also experienced Being With Others was by joining in with them. By joining in with others we mean instances in which the participants sought out and participated in social activities as a response to their feelings of depression. The types of activities they engaged in, the people with whom they joined, and the benefits they gained from joining in with others are described below.

The participants had joined in with others by participating in a number of activities as a way of avoiding or ameliorating the distressing feelings they were having. These activities were either planned and structured or casual and unstructured. Structured activities included organized team sports, student clubs or groups, and church-related events. When depressed, the male participants were particularly likely to play sports including basketball, football, and soccer to join with others. Other participants, both male and female, had responded to their feelings of depression by joining school-based clubs like student government, choir, or special interest groups. One 21-year-old male participant stated, “I joined a group called Pride Out, they teach kids to be drug free. That helped me a lot during depression.” A few female participants had joined in with others by attending religious services. Other participants joined with others by participating in unstructured leisure activities, such as shopping, eating at a restaurant, traveling, “hanging out” at a friend’s home, going to a barbecue, seeing a movie, attending a dance, or going camping. A few participants joined in by providing emotional support to friends who were also struggling with depression as a form of distraction from the participants’ own depressive symptoms.

Joining in with others involved a variety of people. Most participants had joined in with peers for school-based and sports activities. Many participants, however, joined in with family members for leisure and church-related activities. Some participants were strategic about who they joined in with as a way to feel better. One 20-year-old male participant described the people he joined in with:

> When I felt bad I would go out and hang out with friends that were in my outer circle. When I felt more pensive and more reflective I’d hang out with people who were in my inner circle. The difference in the activities would be going out or hanging out with [outer circle] friends … like at a party or at a movie, and inner circle would be going over somebody’s house or going to the park and talking.

Although most adolescents join in with others by participating in activities, the participants in this study joined in with others specifically as a way of combatting their depression. Joining in with others served a variety of purposes for them. Some activities distracted

participants from their distress and the circumstances that had led to their depression, at least temporarily. Being with others took their minds off feelings of sadness, thoughts of self-harm, or a chaotic home life. One 19-year-old female participant who attributed her depression to overwhelming expectations and responsibilities at home participated in the high school choir as “a way to get out.” When describing how church attendance helped with depression, one 21-year-old female participant stated that “it would help, just take my mind off of that stuff when I went to church.” In addition, some participants, especially those who played sports, experienced a release of pent-up emotions. One 21-year-old male participant stated, “I used to play basketball, and go hard at playing basketball, like tired, tired … just to burn off all of the extra energy and built up stress.” For several of the participants, joining in with others had allowed them to connect with, rather than withdraw from, others. One 21-year-old female participant reported “not being lonely anymore” when she joined a club in high school. Another 18-year-old male participant who joined in by providing emotional support to depressed peers said he believed that being a support to others had made him feel better. He said, “I had a handle on the way I felt and if I could help somebody else going through the same thing, then I probably didn’t need the same help from somebody else.”

Having Others Reach Out.—The final way that the participants experienced Being With Others was by having others reach out to them. By having others reach out we mean instances in which participants had been approached or helped by someone who noticed something was wrong. The participants were invited to open up and talk or receive help for their depression. The participant behaviors that triggered others to reach out, the types of people who reached out to the participants, the ways in which others reached out, and the outcomes of their reaching out are described below.

Others typically had reached out to the participants after noticing behaviors that signaled something was wrong. The behaviors of male and female participants that drew the attention of others differed. Others typically noticed male participants who appeared overtly upset. Their facial expressions and body language often signaled their distress. One 15-year-old male participant said his mother knew something was wrong because he would “have a mad face.” Other male participants had others reach out to them in response to harmful behaviors. For example, a 19-year-old male who purposely injured him-self with a knife and a 21-year-old male who committed robberies were offered help by others who cared about them. Occasionally, male participants had someone reach out to them in the absence of noticeable signs of depression. A 21-year-old male participant described the circumstances in which his mother had reached out: “She would always come to me whenever a problem was going on. I don’t know how. I wouldn’t even tell her anything was going on. She would just know something was not right.” Female participants who drew the attention of others were likely to show subtle behavioral changes. Several people had reached out to female participants after noticing that they had withdrawn from normal activities or had become less “talkative.” When describing the changes that caused her mother to reach out, one 21-year-old female participant stated, “I shut down, I didn’t talk any-more. I really didn’t say anything.”

Those people who reached out to the participants knew them either formally or informally. People who knew participants in a formal capacity included personnel within the school and

legal systems. Teachers, coaches, school therapists, and criminal justice personnel had noticed a problem with some of the participants and offered to help. For example, a judge offered help to a 20-year-old male participant who as a teenager had a long history in the foster care system. The participant said, “The judge saw how I was in pain because I wasn’t able to talk to anyone in my [foster] family, and he granted me the rights for me to talk to my [biological] mom.” Most of the people who had reached out to the participants, however, were family members including parents, grandparents, great-grandparents, and siblings. Mothers were most likely to reach out to the participants when they were distressed. An 18-year-old male participant said, “She [his mother] is the only person who would touch that nerve. Nobody else would confront me about depression or about the way I am or the way I act. Or ask me why am I a certain way.” Some participants had mentors or family friends who had reached out to them, and other participants were approached about their depression by close friends or romantic partners. A 14-year-old female participant identified her boyfriend as a person who regularly “tried to see what was wrong” with her when she was depressed.

Participants had experienced having others reach out in a variety of ways. Most commonly others reached out by talking to participants about their problems or feelings. These conversations often ensued when the other noticed a change in a participant’s mood or behavior and asked “what’s wrong?” or “are you okay?” One 13-year-old male participant described a typical interaction with his mother: “Sometimes I get off the bus upset and she asks me, ‘What’s wrong?’ And that’s how our conversations start most of the time.” Some others persisted in their inquiries if the participant did not initially “open up.” One 15-year-old male participant who denied having a problem eventually opened up to his father who “just kept asking.” Participants were most likely to share their distress if others had reached out to them with empathy, kindness, and respect. One 21-year-old female participant had had a previous negative counseling experience with a therapist whom the participant perceived as rude and dis-respectful. She described her encounter with a subsequent school therapist:

> I could talk to her. She didn’t look at you like you’re just faking, this is another kid trying to get a check or something, no. She looked at me like a human being. She talked to me like a person’s supposed to talk to, and she didn’t make my mom feel uncomfortable when she came. She wasn’t rude to me or my mother.

Participants had also received advice, suggestions for coping with their feelings of depression, and words of comfort or encouragement. A 21-year-old male participant received daily encouragement from his girlfriend when she told him “how proud she was” that he was maintaining a steady job and staying out of trouble. Some people had reached out to participants by trying to connect them to a mental health care professional for help with their depression. Female participants were more likely to be encouraged to attend therapy than male participants. One 16-year-old female with depression had been enrolled into therapy in the community by her mother and received a separate referral at school for in-school therapy. In contrast, people more commonly reached out to male participants by engaging them in constructive activities as an alternative to their destructive behaviors. A 21-year-old male participant described how a family friend reached out to him: “She found stuff that I could do so I wouldn’t have too much free time to get into trouble.”

Having others reach out often benefitted the participants. Female participants were particularly likely to feel better because they felt more connected to or loved and supported by those who reached out to them. A 16-year-old female participant described a 2-week "happiness extension" that was powered by her knowledge that she could talk to her boyfriend "no matter what." Several female participants had improved after being connected to formal mental health care as a result of someone reaching out to them. Male participants were likely to feel better after having others reach out to them because they felt calmer and less angry and began to engage in more productive and fewer risky behaviors. One 21-year-old male described the impact of having someone reach out to him: "I started to calm down, started to open up, and started seeing positive [things] there were to do."

Having others reach out, however, was not always beneficial. Some participants, especially females, did not feel comfortable opening up to those who reached out to them. These participants did not believe the other person would understand what they were going through, believed their problems were "no one else's business," or doubted the person's motives for reaching out. Some participants feared negative consequences from discussing their situations with others. A teacher reached out to a 21-year-old female who was having declining grades in high school when the participant became homeless. The participant said, "I talked to her about it. She wanted to bring the law into it and all of that, so I just stopped talking to her."

Discussion

The Being With Others typology presents the multiple ways one sample of AA adolescents managed their depressive symptoms through interactions with other people in their everyday lives. Although participants in this study were asked general questions about how they had managed their depressive symptoms, all discussed interactions they had with other people that influenced their depression. At times, these interactions exacerbated or prolonged the participants' distress, such as when they verbally and physically attacked others or hid their pain from loved ones, whereas at other times the interactions ameliorated their symptoms, such as when the participants got involved in group activities or when they asked for or accepted help from others for their problems.

Although the narratives of young adult and adolescent participant groups were similar, there were some notable differences between male and female participants. Female participants, for example, responded to depression more often by withdrawing from others, while male participants responded more often with overt signs of distress. Whereas female participants became less talkative or stopped doing things they had previously enjoyed, such as spending time with their friends, male participants were more likely to become angry and engage in behaviors that were harmful to themselves or others. Female participants were more likely to be offered formal mental health treatment in response to signs of depression, whereas male participants were more often connected to structured activities like sports or clubs. For female participants, the positive out-comes of Being With Others typically included feeling supported and loved, whereas for male participants, positive outcomes often included feeling calmer and less angry.

Our construct of Being With Others supports the findings of prior studies in which social support was shown to lessen symptoms of depression in AA adolescents (Chandra & Batada, 2006; Lindsey et al., 2006; Lindsey, Chambers, Pohle, Beall, & Lucksted, 2013; Matlin et al., 2011). Just as our participants identified a variety of others who had provided help, Chandra and Batada (2006) reported that AA youth who are depressed get support from family members, friends, and school personnel, such as counselors, teachers, and coaches. Similarly, just as our participants who received help from others often experienced a decrease in feelings of sadness, anger, and loneliness and felt understood, loved, and supported, Matlin et al. (2011) reported that peer and family support decreased depression in AA adolescents.

Our findings can be understood through the lens of theories of coping (Roth & Cohen, 1986; Skinner, Edge, Altman, & Sherwood, 2003). For example, Roth and Cohen (1986) proposed that there are two types of coping: engagement coping and disengagement coping. Engagement coping includes responses that are focused on dealing with the stressor proactively or addressing the emotions stemming from it and consists of activities that include problem solving or seeking social support (Skinner et al., 2003). The participants in our study who sought help or joined in with others evidenced engagement coping. Disengagement coping, on the other hand, includes responses that are focused on escaping the stressor or emotions stemming from them such as withdrawal or denial (Skinner et al., 2003). The participants in our study who kept others at bay evidenced disengagement coping.

The gender differences suggested in our findings had been reported by other researchers (Breland-Noble et al., 2010; Chandra & Batada, 2006; Perkins, Kelly, & Lasiter, 2014). Perkins et al. (2014) found that AA males commonly experienced anger while depressed. Breland-Noble et al. (2010), for example, also found that males were more likely than females to lash out with anger in response to feelings of depression. Chandra and Batada (2006) found that males were more likely than females to engage in sports in response to feelings of depression, and the current study extends these findings by specifying that participants struck out at others and engaged in sports as a way to release pent-up emotions and “burn off” built-up stress.

Findings from our study most strongly resonate with findings from a phenomenological study of AA adolescents’ experience of depression conducted by Ofonedu, Percy, Harris-Britt, and Belcher (2013). These researchers described their participants’ experiences in ways that closely resembled our findings. Ofonedu et al. compared youths’ experiences of living with depression to a storm with lightning (sudden changes in mood) or a “clicking bomb” (anger and rage), whereas our participants described “bottling up” their feelings and experiencing intense anger that was easily triggered by others. Ofonedu et al.’s (2013) finding that adolescents concealed their feelings because they were uncertain of how others would respond is similar to our finding that adolescents kept others at bay and “put on a smile” because they feared being ridiculed or shunned if they “opened up.” Just as many of our participants eventually reached out to others for help, Ofonedu et al.’s (2013) participants also eventually sought or accepted emotional support from family, friends, and others to gradually heal from the pain of depression. Findings from our study are also

similar to findings from a qualitative study describing means of engaging AA adolescents in treatment for depression conducted by Breland-Noble et al. (2010). These researchers described their participants' desire for one of two extremes: to either be left completely alone or for loved ones to reach out to them in very specific ways, whereas our participants described isolating themselves "from everyone" or wanting others to reach out with empathy, kindness, and respect. Breland-Noble et al.'s (2010) finding that adolescents experienced significant distrust of peers, adults, and clinicians is similar to our finding that adolescents often did not feel comfortable opening up to those who had reached out to them because their problems were "no one else's business."

Limitations

Our findings should be understood in the context of the limitations of this study. First, all participants were asked about how they had managed their depression but not asked directly about their interactions and relationships with others. As a result, some participants may not have discussed important interactions that influenced their depression. Second, although the use of retrospective interviews with young adult participants allowed them to reflect upon their experiences with depression during adolescence in its entirety, their memories of the events might have been compromised by the passage of time. We do believe, however, that all participants gave in-depth accounts of events that were meaningful in their lives, and these accounts provided rich data that met the study goals.

Another limitation is that a formal retrospective diagnostic interview was not conducted to determine if the young adult participants would meet *DSM-IV-TR*® criteria for depression (American Psychiatric Association, 2000). Some participants therefore may not have met diagnostic criteria, and others may have had comorbid disorders that could account for some findings. For example, some participants may have had oppositional defiant disorder, the main features of which include losing one's temper, arguing with adults, and showing anger, and this diagnosis could account for participants' behaviors in the category of striking out at others. Despite the lack of a formal diagnosis, however, the participants provided robust descriptions of depression as they had experienced it. In addition, the narratives of the adolescents who had been diagnosed with and were in treatment for depression and the young adults who self-reported depression were not notably different.

Finally, our sample was composed of all AA participants because of our intent to examine how AA adolescents manage depressive symptoms in the face of treatment disparities. However, we cannot claim that any of these findings are specific to AA adolescents. A study comparing how adolescents from different racial/ethnic groups manage depressive symptoms through their interactions with other people would be necessary to draw these conclusions.

Future Research

These limitations provide direction for future research. A longitudinal study that identifies adolescents who are at risk for depression, includes periodic mental health assessments, and interviews participants throughout their high school years would provide valuable data to further develop the typology. Such a design would allow researchers to determine if ways of

being with others change over time or vary according to the adolescents' depression trajectory. A larger, more diverse sample would allow researchers to compare subgroups, such as boys and girls; younger, middle, and older adolescents; and adolescents in various racial/ethnic groups to provide a more nuanced understanding of the role of being with others in adolescent depression. Such a design would allow exploration of ways of being with others that might be unique or particularly salient to African Americans. Important others, such as parents or teachers who adolescents identify as being particularly helpful, could also be included in studies to provide data from multiple perspectives and to further explicate dyadic interactions that constitute the experiences of being with others.

Once the typology is further developed, researchers could develop a tool to measure the degree to which adolescents engage in each way of being with others. Researchers could then examine quantitatively whether particular ways of being with others are associated with outcomes, such as level of depressive symptoms, other comorbid disorders, and quality of life. Such a tool could also be used to determine if interventions that focus on improving the social support of adolescents who are depressed are effective with treatment.

Clinical Implications

Despite the identified limitations, the findings from this study can help psychiatric nurses and other mental health clinicians better understand how AA adolescents manage their depressive symptoms through their relationships with other people in their lives. The typology of Being With Others could be used to assess the variety of ways adolescents engage with or withdraw from people as a way of managing their depression. Specifically, the typology can alert clinicians to patterns of interactions associated with depression in AA adolescents that are not often considered indices of depression, such as putting on a happy face or joining, rather than avoiding activities. Using the typology, clinicians can determine whether or not an adolescent's interactions with others have changed since the onset of depressive symptoms and how these interactions might serve to help manage depressive symptoms.

The typology can serve as a springboard that clinicians can use to initiate discussions with adolescents about their relationships with important others and to encourage adolescents to consider ways in which important others can better help adolescents manage their depression. Table 3 displays example questions developed from the study findings that might guide a discussion with AA adolescents who are suffering with depression.

The Being With Others typology can also be used by professionals who work with adolescents in a number of settings. Teachers, coaches, clergy, and youth leaders might benefit from the typology and our real-world examples of how AA adolescents who are depressed interact with others. Expanding awareness of the multiple ways in which this population manifest their experiences with depression can lead to a timely identification and assessment of depression and referral to appropriate services if needed. In addition, the typology could be incorporated into undergraduate psychiatric nursing courses to help students understand the complexity of depression in AA adolescents.

Conclusion

Although previous research has identified social support as a protective factor for adolescents with depression, the Being With Others typology expands these findings by looking at social support in a multifaceted way. The “real-life” stories provided by our participants reflect the significance of important others in the everyday lives of depressed AA teens. Longitudinal exploration of the five categories of the Being With Others typology could provide insight into relationships between and among the five categories and depression outcomes. Clinicians can use the Being With Others typology to guide important conversations about depression with AA adolescents.

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Table 1.

Demographic Data.

	Young: Adults ages 18 to 21, *n*	Teens: Ages 13 to 17, *n*	Total number, *N*
Female	12	3	15
Male	10	2	12
Student	7	5	12
Single	15	5	20
Employed	11	1	12
Unemployed	11	4	15
No (0) children	12	5	17
1 Child	7	0	7
2 Children	1	0	1

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Table 2.

The Being With Others Typology.

Category name	Category definition	Number of participants	Number of text units
Keeping Others at Bay	Preventing people from knowing about feelings of depression, withdrawing from interacting with others, or spending time alone	22	63
Striking Out at Others	Lashing out verbally or physically at others	19	81
Seeking Help From Others	Seeking help from others	21	44
Joining In With Others	Seeking and participating in activities	19	30
Having Others Reach Out	Being approached or helped by someone who notices something is wrong	23	84

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Table 3.

Discussion Guide for Depression in African American Adolescents.

Depression management category	Description	Question
Keeping Others at Bay	Preventing people from knowing about feelings of depression, withdrawing from interacting with others, or spending time alone	Some teens report that they deal with feelings of depression by keeping others at bay. They keep their feelings bottled up or hide them from others by putting on a happy face. Sometimes they feel like they can't be completely honest about how they feel. Is that something that you do? If so, tell me about some times you have done this.
Striking Out at Others	Lashing out verbally or physically at others	Some teens report that they deal with feelings of depression by striking out at others. They release built up anger by yelling, cursing, or physically fighting; are viewed at home or school as being in a bad mood; or have times when they "flip out" on people around them. Is that something that you do? If so, tell me about some times you have done this.
Seeking Help From Others	Seeking help from others	Some teens report that they deal with feelings of depression by seeking help from others. The have people they feel comfortable talking to when they are upset or ask for help with their problems. Is that something that you do? If so, tell me about some times you have done this.
Joining In With Others	Seeking and participating in activities	Some teens report that they deal with feelings of depression by participating in extracurricular sports, school-based clubs like government, choir, band, or orchestra, or do things with people outside of school like going to the movies, shopping, or hanging out at someone's home. Is that something that you do? If so, tell me about some times you have done this.
Having Others Reach Out	Being approached or helped by someone who notices something is wrong	Some teens report that when they are upset or sad, people in their lives notice. These teens have people who ask how they're doing or if they're okay or people who get them to talk about their feelings. Do you have people in your life who do that? If so, tell me more about those people.

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